

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

Requestor's Name and Address: PRESBYTERIAN HOSPITAL OF PLANO 3255 W PIONEER PKWY ARLINGTON TX 76013-4620	MFDR Tracking #: M4-09-6115-01
Respondent Name and Box #: Texas Mutual Insurance Co. Box #: 54	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "There was a CCH held to determine who is responsible for payment of charges for this date of service. The decision states that the compensable injury includes the abdomen-but not the pelvis. We rebilled Texas Mutual and asked for payment for the CT for the abdomen. They are refusing to pay. I am filing this MDR within 60 days after the CCH decision to preserve my rights and to appeal for appropriate payment."... "Knowing that TDI moved to a %-over-Medicare allowance for hospital claims, we have reviewed the Medicare APC allowance and decided the correct reimbursement is \$509.38. Medicare would have allowed this facility \$363.84 for CPT code 74160. Allowing this at 140% is \$509.38."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - \$509.38
3. Hospital Bill
4. EOB
5. CCH Decision and Order

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "This requestor failed to submit its request for MDR in accordance with DWC Rule 133.307 and within the specified one year frame from date of service in dispute. The Division received the medical dispute resolution request from the requestor on 2/10/2009; (See Requestor's DWC-60 packet) which is past one (1) year from the date of service."... "Given the above, Texas Mutual believes DWC has no jurisdiction to proceed with medical dispute resolution as this is not a proper request for dispute resolution"...

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
7/23/2007	CAC-47, 246	CT Scans	\$509.38	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code
 - CAC-47 – “This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
 - 246 – “The treatment/service has been determined to be unrelated to the extent of Injury. Final adjudication has not taken place.
2. The respondent's position statement asserts that “This requestor failed to submit its request for MDR in accordance with DWC Rule 133.307 and within the specified one year frame from date of service in dispute.” Review of the submitted documentation finds that the request for Medical Fee Dispute Resolution was received by the Division on February 10, 2009. The date of service in dispute is July 23, 2007. A benefit contested case hearing was held on December 18, 2008 to decide a disputed issue related to compensability. A decision and order was issued by the hearing officer on December 31, 2008. Per Division rule at 28 TAC §133.307(c)(1)(B)(i) effective May 25, 2008, 33 TexReg 3954, applicable to disputes filed on or after May 25, 2008, a request may be filed later than one year after the date(s) of service if “a related compensability, extent of injury , or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability.” The request was filed within 60 days of requestor receipt of the compensability decision. The request is therefore timely.
3. This dispute relates to outpatient radiological services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §134.401(a)(3), effective August 1, 1997, 22 TexReg 6264, states that “Services such as outpatient physical therapy, radiological studies and laboratory studies are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services”...
6. Division rule at 28 TAC §133.307(c)(2)(A), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include “a copy of all medical bill(s)”... “as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter”... Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of all medical bill(s) as originally submitted to the carrier and/or as submitted for reconsideration. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(A).
7. Division rule at 28 TAC §133.307(c)(2)(B), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include “a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB.” Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of the EOB detailing the insurance carrier's response to the request for reconsideration. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(B).
8. Division rule at 28 TAC §133.307(c)(2)(E), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include “a copy of all applicable medical records specific to the dates of service in dispute”... Review of the documentation submitted by the requestor finds that the requestor has not provided medical records to support the services in dispute sufficient to meet the requirements of 28 TAC §133.307(c)(2)(E).
9. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, which requires that the request shall include “a position statement of the disputed issue(s) that shall include”... “how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues”... Review of the requestor's position statement finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not filed the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iii).

10. Division Rule at 28 TAC §133.307(c)(2)(G), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable”... The requestor’s position statement asserts that “Knowing that TDI moved to a %-over-Medicare allowance for hospital claims, we have reviewed the Medicare APC allowance and decided the correct reimbursement is \$509.38. Medicare would have allowed this facility \$363.84 for CPT code 74160. Allowing this at 140% is \$509.38.” However the requestor did not discuss or explain how it determined that 140% of the Medicare rate would yield a fair and reasonable reimbursement. Nor did the requestor submit evidence, such as redacted EOBs showing typical carrier payments, nationally recognized published studies, Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments, to support the proposed methodology. Nor has the requestor discussed how the proposed methodology would be consistent with the criteria of Labor Code §413.011, or would ensure similar reimbursement to similar procedures provided in similar circumstances. Review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that the payment amount sought is a fair and reasonable rate of reimbursement in accordance with 28 TAC §134.1. The request for additional reimbursement is not supported.
11. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(A), §133.307(c)(2)(B), §133.307(c)(2)(E), §133.307(c)(2)(F)(iii) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.250, §133.307, §134.1, §133.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.